Executive Committee
Summary of Meeting Minutes
January 4, 2018

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
David Hudson – **present**	Michael Randol - **present**
Dennis Tibben –	Deb Johnson - **present**
Dan Royer – **present**	Liz Matney - **present**
Shelly Chandler – **present**	Matt Highland - **present**
Cindy Baddeloo – **present**	Lindsay Paulson - **present**
Casey Ficek – **present**	Sean Bagniewski - **present**
Lori Allen – **present**	Luisito Cabrera - **present**
Richard Crouch – **present**	Alisha Timmerman -
Julie Fugenschuh – **present**	
Jodi Tomlonovic – **present**	

Introduction
Gerd called the meeting to order and performed the roll call. Executive Committee attendance is as reflected above and quorum was met.

Approval of the Executive Committee Meeting Minutes of December 19, 2017
Minutes of the Executive Committee meeting of December 19, 2017 was approved.

Long Term Services and Supports Presentation (LTSS)
Deb Johnson handed out copies of the document, "Medicaid Home-and Community-Based Services (HCBS) Program Comparison Chart" which outlines the various services under LTSS.

She stated that LTSS consists of Home- and Community-Based Services (HCBS) Waivers and Institutional Care:

Home- and Community-Based Services (HCBS) Waivers
Deb stated that HCBS is part of the Social Security Act and is referred to as the 1915c HCBS Waivers. There are seven waivers; Health and Disability; AIDS/HIV, Elderly, Intellectual Disability, Brain Injury, Physical Disability, and Children's Mental Health. HCBS Waivers provide service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. She stated that waiver services are meant to complement or supplement the state plan or other resources that are available. Waiver participants have access to the full state plan but that they still need to meet the institutional Level of Care and services have to be cost-effective or less expensive in aggregate than what it would cost in an institution.

Institutional Care: Nursing Facilities (NFs), Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs), and Intermediate Care Facilities for the Intellectually Disabled (ICF/IDs)
Deb stated that members receiving these services need to meet the same Level of Care and income guidelines as in waiver programs. There are monthly maximums or caps on the financial amount for services in each program and this is important in determining the aggregate for cost neutrality. She added that cost-effectiveness of services is determined on an individual basis and is based on a variety of variables. Deb provided clarification on the distinction and relationships between Level of Care, service plan, and care coordination.

Quarterly Report Data Presentation

The Q1 SFY18 report was made available in the materials packet. Liz stated that all members that receive community services or are in a waiver program have an assigned care coordinator or case manager but not all members in facilities have assigned care coordinators or case managers. Liz reviewed HCBS-specific data and case management ratios of MCOs for members receiving community-based services, and discussed surveys. Liz stated she would provide additional information regarding annual state savings at a future meeting.

Care Coordination and Conflict-Free Case Management

1. **UnitedHealthcare**
   Kellyann Light-McCoroary, stated that UnitedHealthcare's Case Managers (CMs) focus on person-centered planning while ensuring compliance with state and federal regulations. UnitedHealthcare CMs are nurses as well as social workers and they have extensive training in LTSS. Upon hiring, CMs are put through training in LTSS and each CM hired is paired with a mentor. She stated that UnitedHealthcare follows conflict of interest requirements as outlined in the Code of Federal Regulations. She stated that all states are required to separate case management person-centered service planning development from service delivery. She stated that for assessments, UnitedHealthcare utilizes inter RAI and the SIS as required by the State. Assessors are certified and carry out case reviews, ride-alongs, and peer reviews.

2. **Amerigroup**
   Kelly Espeland stated that Amerigroup has assessments teams that do assessments with the members and are facilitators of those assessments. In regards to the SIS assessment, the CM is a facilitator and does not determine the score or the member's needs as this is carried out by the team. Assessors are trained by AAIDE and assesors are reviewed and certified annually by AAIDE. The information then goes to the CM, the team reviews the information, and the CM provides the service coordination to develop the member's person-center plan based on identified needs. She stated that the UM team looks at the assessment and care plan that has been developed, and a determination is then made regarding services. She stated that oversight within their organization consists of: member appeals rights available if they disagree with a decision; contractual requirements and guidelines, and; External Quality Review (EQR) audits.

   Member advocacy during appeals hearings was discussed. It was clarified that the CM facilitates the service planning meeting and the member selects their care team. Kim Foltz stated that conflict-free case management means that the provider cannot be the assessor, care planner, and the delivery/service provider. It was stated that the contract between the State and the MCOs is a risk-based arrangement.

Medicaid Director's Update

The Action Items document was made available in the materials packet. Update postponed to February 27, 2018, Executive Committee meeting.

Mobile Applications
Matt Highland to discuss at February 27, 2018, Executive Committee meeting.

Open Discussion

There was no open discussion due to lack of time.

Adjourn

4:45 P.M.